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Assessing Needs of Care in European Nations

THE LITHUANIAN LONG-TERM CARE SYSTEM

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1. The system of LTC of Lithuania

1.1 Overview (summary) of the system

In Lithuania there is no separate public sector for the long term care as in almost all countries of Central and Eastern Europe. Social and health care services offered for elderly people are organized through three main sectors: health care, social system and private sector together with non-governmental organizations. The lack of distinction of the system causes that no unified legal arrangements have been created and there is no central or/and regional institution that regulates uniformly the long term care procedures. The long term care are provided within the health care system and social services system with the first one concentrated on the long term care to the disabled and chronically ill and the second one concentrated on care provided to the dependant people, among which are also elderly. Only recently (in 2007), the operational definition of long term care was formalized for the first time¹. According to *Social Report 2007-2008* the long term care is oriented towards shifting from an institutional care to home based care. The philosophy of the LTC system is to develop a flexible forms of provision of long-term care (at institutions, day centers and at home), to support informal long-term care (by relatives, family members, neighbours, non-governmental organization and volunteers) in order to raise the support of natural, family environment².

According to some evaluations, within the health care sector during the 90's mostly institutional care prevailed. Up to 30% of hospital admissions were for nursing care alone due to the relatively big supply of hospital beds (WHO, 1996). After 1996 many small rural hospitals have been transformed into nursing facilities. From 2007 long term medical treatment is provided on nursing and residential care facilities. Long term medical treatment is provided irrespective of the age, but considering the health condition, the progress of disease and complications. Within the health care system there are created nursing hospitals which cover nursing care follow-up treatment, medical rehabilitation, sanatorium treatment and palliative care.

Up until 1990, the main focus of social care was institutional care for the elderly and the physically and mentally disabled. Long term care at home was an activity divided mainly by family members. Only recently, the strategy of the long-term care provision has been concentrated more on the new forms of long-term care home provision. New long term care services within the social sector have been defined and listed within the Catalogue of Social Services created under the responsibility of the Ministry of Social Security and Labour. Long term care in the social system is provided irrespective of age, but considering the level of independency and the need for care. The social system provides social help in day centres, home care services and care in stationary social care institutions. Also the support of informal care has been developing under social services.

¹ Long Term Care is defined as an entirety of care and social services by providing which care and social need of a person are met and continuous comprehensive help and supervision by specialists are provided (National Report on Lithuania on Social Protection and Social Inclusion Strategies, 2008-2010)

² National report of Lithuania (2008)

The development of the long term care sector is a huge challenge resulting from demographical changes and ageing tendencies of the population. Nowadays, the capacities of long term care homes in both sectors: health care and social care is estimated at 2,5 places per 10 thousand inhabitants, which is much less when estimating the increasing needs and much below the average of EU-15.

1.2 Assessment of needs

The assessment of needs and the evaluation of care dependency required for long term care is different in social and health care sectors.

In social sector services are provided irrespective of age, considering the level of independency and the need for services. Eligibility criteria depends on the level of dependency, the need for services and on income and the property of the individual. The need for social services including long term social care is determined by social workers. It may also be done by a team of specialists, which consists of social worker, his assistant, community caregiver, mental health caregiver. Social worker visits an individual, analyses the conditions and decides what type of social help is needed. According to the determined scale and scores selected, a person can be self-sufficient, partially self-sufficient and dependent. Every category depends on the complex system of indicators and entitles to the different services depending on certain situation. Community relations, communicativeness, spending of leisure, his ability to accept the help of others, nutrition, housework, his financial abilities, cognitive, emotional, perception and other functions are evaluated to determine the need for social services.

Persons in need of care from another person that require care no more than 4 hours per day and 5 days per week may receive home attendance. If they need care for no more than 8 hours per day and no more than 7 days per week, they might receive social care at home or stay in day centres. If they need of care more than 8 hours per day, they could receive temporary short-term social care at home and in care institutions, but no more than 30 days. Otherwise, they might obtain long-term social care for more than 30 days in stationary social care institutions.

The amount of payment for long term care depends on financial possibilities of a person (income and the property).

Long term medical treatments with nursing services are available for all citizens and the eligibility is based on the health insurance coverage. They are provided irrespective of age, but considering the health conditions, the progress of disease and complications. The special need of disabled is determined by certified list of person's health care conditions. It is determined by a doctor or medical advisory commission only according to approved medical indicators, and there are no other indicators taken into consideration. There are no categories for the long term medical care. Disabled people, considering their special needs, may be provided by permanent care (assistance) or by permanent nursing.

1.3 Available LTC services

1.3.1

Which services?

The long term care are provided within the health care system and social services system. In the first one services are concentrated on the long term care to the disabled and chronically ill

(palliative care is also included). Social services are addressed to all dependant people, among which are also elderly.

Within the health care system there are created nursing hospitals which cover nursing care follow-up treatment, medical rehabilitation, sanatorium treatment and palliative care³. The social system provides social help in day centres, home care services and care in stationary social care institutions⁴.

Nursing services within health care sector are available both for in-patients and out-patients. Stationary long term medical treatment with nursing services is available for patients with chronic diseases or disability. Patients must be referred to the long term care by the physician of an ambulatory or a stationary health care institutions. The patient can be treated in the stationary long term care institution (called supportive treatment hospitals) if he suffers from a disease which is enrolled into the list of medical indications approved by the Ministry of Health. Patients can be hospitalised after the final diagnosis without any additional tests.

The special need for **permanent nursing** is indicated for people with severe disability, who require permanent care and whose physical and psychical disability seriously restricts the possibilities to orient, move, walk and independently keep their private and social life. The need for additional **permanent care (assistance)** is determined for people with very serious disorders of organism functions, who need the permanent care of another person at home in their private and social life.

Home care includes nursing and social care services, which are provided by various professionally prepared workers at home of the needed care persons. These services are provided to people that are unable to live at their home self-dependently and who partly lost their independency due to old-age or disability.

Elderly and disabled people can also receive day care in **day care centres** no more than 8 hours per day and no more than 5 days per week.

In **stationary social care institutions** long term care is provided for people who are totally dependant and who need the permanent care of professionally prepared caregivers. Still, the health status of the person admitted to stationary social care institutions is relatively better than patients of the nursing hospitals. Stationary social care institutions are available in all main regions of the country under the supervision of local governments. The minimum duration of stay is 1 month.

If a local authorities are not able to provide needed social services, they may pay so called **“money for care”**, so the recipient should buy needed services on a private basis. Benefits in cash are only paid directly to the dependant person. The amount of the target compensation for nursing expenses at home varied between 1.5 -2.5 times the social insurance basic pension and depended on the category of the recipient. From the 1st January 2007 this allowance is 2,5 time the social insurance basic pension without differentiation. The amount of the target compensation for care corresponds to 0,5 times the social insurance basic pension. Financial contribution towards the provision of these services depends on person's (family's) income.

³ Law on Health Care Institutions

⁴http://ec.europa.eu/employment_social/missoc/db/public/compareTables.do;jsessionid=K44Ch7Dv2JTdqVRvRXGmZrFySB95QL1M5v19pM0N415QV2dGWmvp!-1209140689

1.3.2

Who is eligible?

The eligibility criteria for long term care are different within the health care and social sector.

All persons insured in the public health insurance are eligible to the long term care provided within the health care sector. Eligibility criteria depends on health condition, the progress of disease and complications.

Services within the social sector are provided to a person who, by reason of his age, disability, social problems, partially or completely lacks, has not acquired or has lost the abilities or possibilities to independently care for his private (family) life and to participate in society. Eligibility criteria depends on the level of independency, the need for services and on income and the property of the individual. Cash benefits are not means tested. Benefit is paid if persons defrays at least 1/3 of set fee for long-term social care (currently LTL 936 (EUR 271)).

1.4 Management and organization

From 1998 to 2000 decentralization of social care institutions and health care have been taking place. All institutions which were subordinated to ministries have been passed over to territorial self- governments. The major responsibility falls under the **local self- government (municipality or county)** which is in charge of the ensuring of provision of the long term services to residents of its territory by planning and organizing social and health care services, and controlling their quality. Because of the insufficiency of local funds some self- governments do not arrange relevant services or they provide them with low quality.

National government is responsible for long-term national programmes and strategies. More specifically, **The Ministry of Health** is responsible for the entire health care system policy. It also has the overall responsibility for the public health system's performance. Through the State Public Health Center it manages the public health network including ten county public health centers with their local branches. **The Ministry of Social Security and Labour** is responsible for adoption of long term national programmes and strategies for the social integration within social sector. Local self-governments are responsible for the process of assessment of needs, monitoring and control and contract social services to the services providers.

The market of social care does not yet exist because there is **no competition in this field**. Long term care in social sector is being mainly provided by local social care institutions which do not have to compete for their clients – on the contrary, queues of elderly people willing to gain entrance to social long term care institutions are still being traced. Moreover, due to underdeveloped structure of alternative services long-term social care institutions are fully accommodated and there are long waiting lists of persons willing to get a place therein.

1.5 Integration of LTC

Within the LTC system

As already mentioned the provision of the LTC is divided into two areas, health care services and social care services. Until 2007 there was no single concept of long term care. From 2007 the Ministry of Health and the Ministry of Social Security and Labor aim at improving coordination of care and social services at the municipality level, improving cooperation and communication between institutes and accessibility of these services. However, no legislative or financial integration is defined within the LTC system.

Between health care and social services sector

As there is no specific (separate) legislation for LTC system, all services are either integrated with health care or with social systems. Health institutions for elderly people with long term care needs are organized and funded on the same basis as other health care institutions. Social services for people with long term care needs are organized and funded on the territorial self-government basis within social system. Consequently, each long term care service might be funded from different source and be integrated with one of the sectors mentioned above.

2 Funding

Expenses related to long term care within health care system are being financed from various sources:

- Compulsory Health Insurance Fund, following the order set by the Law on Health Insurance,
- the state and territorial self-government budgets,
- the EU structural funds,
- private financial resources,
- charity and other legitimate sources.

Health Insurance Fund finances long term medical treatment with nursing services no longer than 120 days each year.

Long term care within the social system is financed from local self-governmental budgets and target subsidies of the central budget assigned to local (municipal) budgets. In this respect municipalities directing persons to social care institutions for long term care shall have to cover part of the expenses related with provision of social services. To make more rational use of the state budget funds, persons themselves contribute to payment for long term care services using not only their income but also their property. The amount for long term care paid by a person must not exceed 80% of the person's income⁵. It depends on the kind of long term care and the person in need of care. Self-governments have the right to relieve person from payment. Moreover, the state does not control the prices of services.

⁵ The Law on Social Services, 2006

As shown, because there is no separate source of funding for long-term care provision each type of services is provided as a part of more complex structure. Consequently, it is impossible to distinguish the total amount of money spent on long term care services only. Despite this, some attempts have been done in order to approximately present the situation. Data available in Lithuanian National Statistical Office show that during the years 2004-2008 the relative expenses on nursing and residential care facilities within the health care sector remain the same balancing between 35% - 40% of total expenses (Table 2). Within the last 10 years the expenses on support in old age by type of benefit within social sector increases (Table 3).

Table 1. Expenditures on health care by providers of health care, nursing and residential care facilities

Expenditure on health care within nursing and residential care facilities	2004	2005	2006	2007	2008
Total in LTL million	1 262,8	1 545,3	2 063,5	2 397,1	2 708,7
Structure of the total health care expenditure, %	35,3	36,6	40,0	39,0	36,8

Source: Lithuanian National Statistical Office

Table 2. Support in old age by type of benefit within social sector

	2000	2001	2002	2003	2004	2005	2006	2007
Social protection benefits	3 065,1	3 010	3 063	3 230,2	3 482,1	3 913,2	4 354,1	5 951,3
Cash-benefits	2 975,4	2 919,7	2 974,	3 134,6	3 370	3 795,4	4 212,2	5 802,1
Care allowance	n/d	n/d	n/d	16,6	20,9	42,9	74,3	172
Benefits in kind	89,7	90,3	89	95,5	112,1	117,7	141,9	149,2
Assistance in carrying out daily tasks	5,1	5,1	4,6	6,7	7,2	7,3	7,8	13,9

Source: Lithuanian National Statistical Office

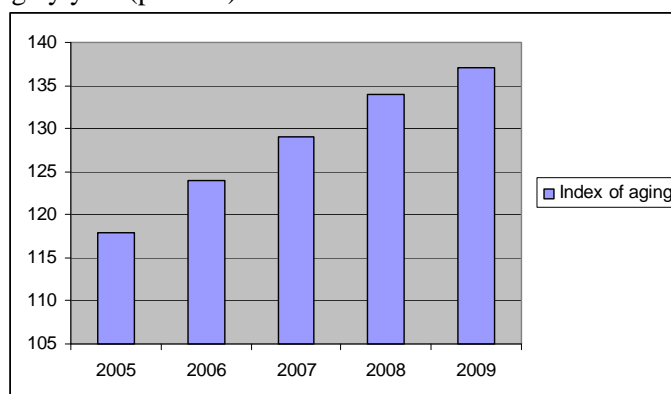
Please note that numbers provided cannot be representative under any respect as they reflect only share of expenses on long term care.

3 Demand and supply

3.1 The need for LTC (including demographic characteristics)

Public documents or the National Statistical Office do not provide evaluation of needs for long term care. The demand can be approximated by demographic characteristics only. According to “Country Case Studies in Long-Term Care” the demand for the long term care remains high. The middle-aged population’s longer average lifespan, and the progress in the field of medicine have greatly contributed to an increasing number of disabled and older people who have difficulty caring for themselves. At the beginning of 2003, 19,8% of the country’s population were 60 or more, in 2008 the number was higher and amounted to 20,52% (see Table 3). Also the index of ageing in Lithuania consistently increases from 2005 (Figure 1).

Figure 1. Index of aging by year (persons)



Source: National Lithuanian Statistical Office

Table 3. Structure of the population by age

	2001	2002	2003	2004	2005	2006	2007	2008
Share of population aged 60+	14,2%	14,2%	14,4%	15,0%	15,1%	15,3%	15,7%	15,8%
Share of population aged 85+	2,3%	2,4%	2,4%	2,8%	2,8%	2,9%	3,1%	3,3%

Source: National Lithuanian Statistical Office

Results of the European Commission survey on ageing (2009) indicate that life expectancy at birth for males will increase to 80 years old for males and almost 87 for women by 2060. It is foreseen that the life expectancy at age 65 will increase to 20 years for men and almost 24 for women (Table 4), which is below the average of the EU (the corresponding numbers are 21,8 for males and 25,1 for female). It is estimated that every third inhabitant of Lithuania will be an elderly person in 2050⁶.

Table 4. Selected demographic indicators, 2008-2060

	2007/ 2008	2010	2020	2030	2040	2050	2060
Life expectancy at age 65, males	13,1	13,4	14,9	16,3	17,7	19,0	20,3
Life expectancy at age 65, females	17,5	17,8	19,0	20,3	21,5	22,6	23,7
Life expectancy at birth, males	65,9	66,6	69,8	72,8	75,6	78,1	80,4
Life expectancy at birth, females	77,4	77,9	80,0	81,9	83,7	85,3	86,9

Source: European Commission, 2009 Ageing report

National Lithuanian Statistical Office provided one-year (for 2005) information about people having at least one physical or sensory functional limitation and about people having difficulties in doing household care activities (Table 1). Those statistical data showed obvious findings. The older the respondents, more difficulties they have in household care activity and might need care and social services. Unfortunately, the lack of information for other years unable the evaluation of changes in the needs for the LTC in time.

⁶ Lithuanian National Statistical Office, "Demographic situation in Lithuania", 1990-2002

Table 5. Population, who have difficulties to do household care activity

Persons, who have difficulties to do household care activity	in % of total population
Total	12,1
By gender:	
• Male	9
• Female	14,6
By age:	
• 15-24	2,3
• 25-34	3
• 35-44	4,3
• 45-54	7,5
• 55-64	16,1
• 65-74	27,2
• 75-84	49,1
• 85+	73,5

Source: National Lithuanian Statistical Office, 2005.

To establish the need for care and social services for elderly people, an extra study was carried out by Hitaite and Spirgiene (2007) ⁷. In this study authors assessed the needs of the elderly for nursing and social services in Kaunas Region. 390 persons were interviewed representing all elderly people of the region. According to the respondents, 71,3% of them needed nursing services and 58,2% needed also social services. In the group of fully or almost fully dependent persons 88% of respondents indicated that they needed social services and 96% needed nursing services. Rural residents needed social services more (64,3%) than urban (49,6%). As many as 45,9% of respondents pointed out that they found it difficult to travel to visit a doctor. The majority of respondents (86,4%) emphasized that persons taking care of them did not have medical background. The majority of respondents (79,2%) would like to be cared for at home. This research indicates that the needs for care remain undoubtedly high.

3.2 3.2. The role of informal and formal care in the LTC system (including the role of cash benefits)

The formal long term care in Lithuania is still deeply undeveloped and biased toward provision of an institutional care. A number of social projects have started in order to expand the supply of formal long term care, especially home based care. Despite a present increase in support for caring activities by governmental and non-governmental organisations, most care provided for the elderly and disabled is still carried out by family, neighbours, friends and volunteers.

3.3 Demand and supply of informal care

In Lithuania the demand and supply of informal care have not been regularly studied. The study of the need for nursing and social services in the Kaunas district by Hitaite and Spirgiene (2007) has indicated that 69,7% of elderly people that needed home nursing were cared for by family members, 10% of them were cared for by neighbours, 7,7% by

⁷ Hitaite, L. and L. Spirgiene, 2007, The need of the elderly for nursing and social services in the community of Kanas district, „Medicina (Kaunas), 2007, 43 (11), www.medicina.kmu.lt

community nurses and only 3,8% of them paid for this service. The supply of informal care is still high in Lithuania. The same study reveals that the majority of respondents would like to be cared for at home. It shows the preferences of elderly people toward home care. However, demographic changes (e.g. the rapid aging of the population, migration from rural to urban areas, etc.) and employment changes (e.g. the increase in the percentage of women in the labour force) is already making increasingly difficult for the informal care system to continue to carry such a high burden of caring responsibilities for the elderly and disabled. In consequence, these factors demonstrate the growing formal long term care needs in the country.

3.4 Demand and supply of formal care

3.4.1 Introduction

In Lithuania there is no regular study on the demand of formal care (institutional or home based). The demand for LTC is approximated by the demographic and epidemiologic structure of population on national and regional level. Until 1990, the main form of long term care was institutional care for the elderly (retired pensioners) and the physically and mentally disabled, provided only by governmental care institutions. Home based long term care provided by the social system was a new phenomenon in Lithuania in the middle of 90's and it is still in the process of constant development. At present the changes in the structure of the supply of formal care is mostly dependent upon political objectives of the government.

3.4.2 Institutional care

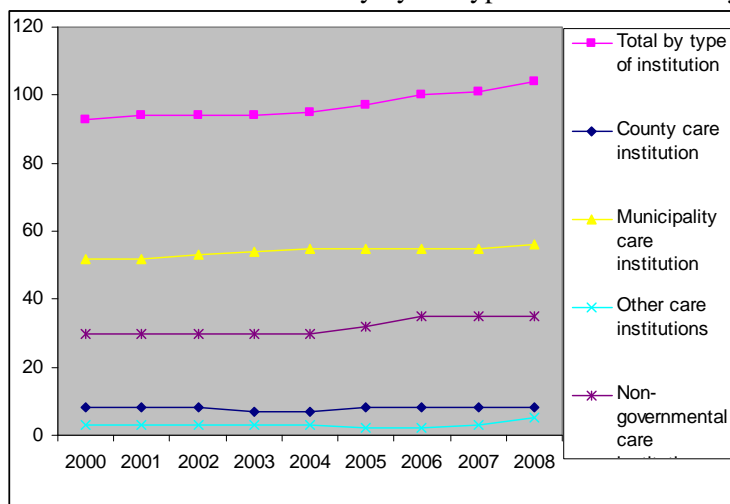
According to their subordination, long term social care institutions are divided into county institutions, municipal institutions and non-governmental institutions. At the end of 2005 there were 194 long term social care institutions of various types and subordination, out of which:

- 66 county subordinate social care institutions, where 9 social institutions are for elderly people;
- 128 social care institutions of other subordination (municipal, non-governmental and others) out of which 88 social care institutions are for elderly people.

Figure 2 presents the changes in the number of long term care institutions for the elderly people during the last 8 years. As shown the supply of institutions overall slowly increases. This slow growth is mainly attributed to the slow increase of the non-governmental social care institutions.

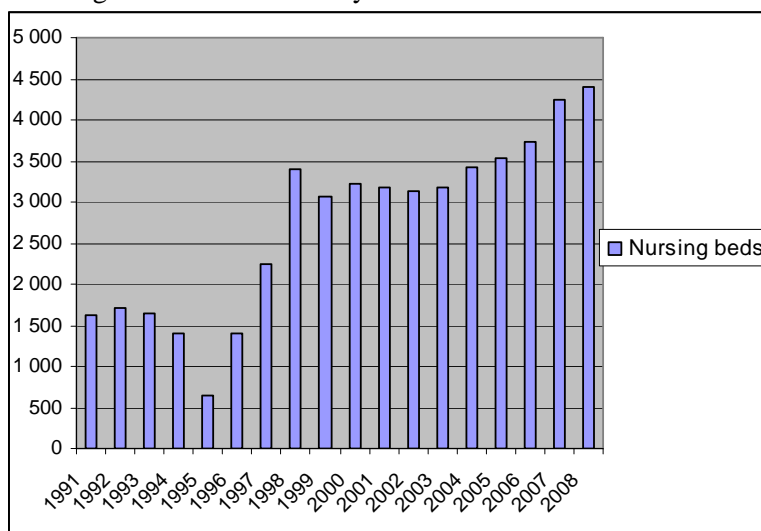
The increased number of long term care institutions for elderly people is accompanied by the increase in number of places in such institutions. According to the National Lithuanian Statistical Office in 2000 there were 4 711 beds. The number increases to almost 5 350 beds by the end of 2007. Also the number of nursing beds within the health care sector has been increasing from 1996 (Figure 3).

Figure 2. Number of care institutions for the elderly by the type of institution and year



Source: National Lithuanian Statistical Office

Figure 3. Number of nursing beds in health care system



Source: Lithuanian National Statistical Office

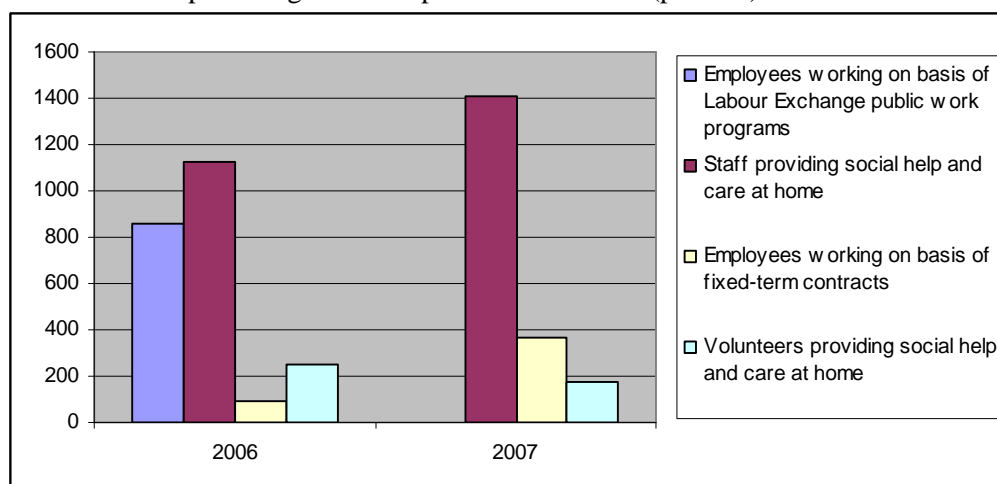
According to the report of the Ministry of Social Security and Labour (2009)⁸ self governments are still in favour to provide institutional care instead of providing with alternative home based services.

3.4.3 Home care

Carers and social workers provide long term home care, which includes nursing, shopping and help at home. In 1997, more than 2 200 carers were involved in care delivery through the country. This number has increased (Figure 4), but it is still undoubtedly insufficient to meet the current need. Despite the support by (non-)governmental institutions, long term care in the community remains an activity carried out mainly by families, neighbors, friends and volunteers.

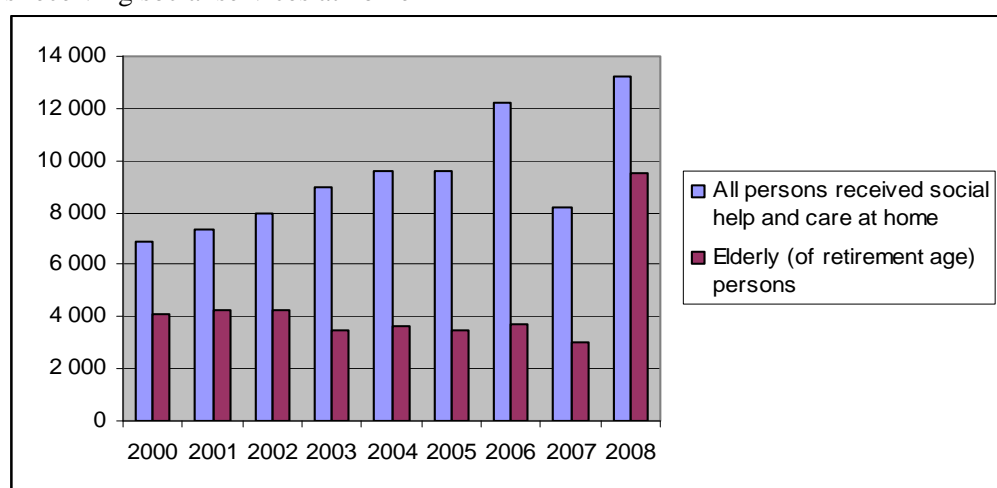
⁸ Ministry of Social security and Labour and Vilnius University, Department of Social Work, 2009, „Social Services in Lithuania”; Egle Radisauskiene, Laimute Zalimienė.

Figure 4. Carers and volunteers providing social help and care at home (persons)



Source: National Lithuanian Statistical Office

Figure 5. Persons receiving social services at home



Source: National Lithuanian Statistical Office

The number of people receiving social help and care at home increases between 2000 and 2008. The number of elderly people that receive social help and care at home remains relatively constant balancing between 3 000 - 4 000 people between 2000-2007. Only recently (2008) this number has increased rapidly (to almost 9 000 people) (Figure 5). Unfortunately, there is no information available on the supply of long term home care in 2008, so no explicit explanation might be attributed to such a change. The reason might be the increase in the supply of such social services or the changes in the policy the government implements.

4 LTC policy

4.1 Policy goals

In Lithuania there is no single legislation that is responsible for the LTC issues only. The main applicable statutory basis are “Law on Social Services of 19 January 2006” and “Law on Health Care Institutions of 6 June 1996”. Consequently, LTC policy changes are based on the changes in the law of these two sectors.

According to *Social Report 2007-2008* the long term care is oriented towards shifting from an institutional care to home based care. Thus the aim of the reform of 2002 is to reorganise the social services in such a way that legal, administrative and financial premises were created enabling to provide and organise social services in a community, to make social assistance more efficient and encourage a person to actively search for ways of long term home care, rather than using stationary means of social assistance. The second very important focus of the reform is placed on the improvement of the quality of social services as well as the improvement in the way of financing social services.

Priority policies related to health care reforms are concentrated on the increase of efficiency, accessibility and quality of health care and services. Given the increase in the number of elderly people medical expenses are growing, the public becomes more concerned with health care and quality of its services, which is why the government tries to create equal conditions for all citizens of the country to get access to the health care services needed.

4.2 Integration policy

As in Lithuanian Law there is no united and no separate legislation for the long term care, some attempts for integrating services provided within health and social services were made. The approved Primary Healthcare Development Concept lists measures to improve integration of care and social services into primary health care, to develop a range of long term care services at home for elderly people. However, this is just a first step for the integration of LTC services and much more has to be done to improve it.

4.3 Recent reforms and the current policy debate

The last reform of the Law on Social Services, of which part are long term care services entered into force in 2006. According to this reform the functions and the responsibility between the ministry, counties and municipalities were clearly distributed, the competition between social services' providers encouraged, the order of the social services' financing changed from direct financing of institution, to direct financing of social services, the payment of social services differentiated according to the principle of social solidarity, the quality requirements for social services settled.

The fragmentary changes in the long term care structure are implemented through several kinds of national/local programmes. Their detailed description is presented in the *Social Report 2007-2008* prepared and published by the Lithuanian Ministry of Social Security and Labour. The aim of one of the project described on "Vocational Training of Social Workers and Assistants of Social Workers" was to increase quality of social services through the improvement of professional competence of social workers. As a results of the implementation of the project about 4 000 social workers and assistants of social workers received training in 2006-2009.

In 2008 the draft Description of Procedure of the Certification of the Heads of Social Service Institution was prepared. The aim of the procedure is to evaluate the qualification of the heads of social service institutions, their operational results, to award them with an appropriate management qualification category and to encourage the efficiency of activities through the implementation of state social service policy and seeking high quality of social services.

The years 2007-2008 saw the implementation of the Social Service Infrastructure Development Program. Its aim is to create condition for the development of social services by providing the residents with possibilities of using social services, municipal institutions, foreign partners, regions, private and public sector. The funds allocated are used to construct, reconstruct as well as modernise existing social service institutions.

From 2008 the **Social Care Standards** were supplemented together with the assessment criteria. These standards place the major focus on a human right to privacy, preservation of dignity and honour, harmonisation of emotional needs and the environment created for a person, creation of conditions favourable for the self-expression and the development of interests, strengthening of social ties with a community and relatives. One of the key features of the quality assessment mechanism, which is in process of the creation, is methodological assistance and sharing of “good practices” between institutions and workers of social care institutions. The purpose of granting a license is to ensure good quality of services rendered by social care institutions.

5 Critical appraisal of the LTC system

The main critique of the long term care system in Lithuania is its division between health care system and social system and weak integration of these two parts of care services. Several institutions function without the collaboration with other bodies in the same field. The creation of the long term care policy is at its initial stage and it is concentrated more on some small issues than on the overall systemic reform, particularly on integration of LTC services in one sector. Despite one of the aims of Health Care Reform⁹ to strengthen the cooperation of the health care and social security institutions to 2005, until now only the inter-sectoral group was formed to prepare proposal on incorporation of care homes, nursing hospitals and hospices into the health care sector. The experience of the European Union member states shows that in order to ensure conditions for elderly people to live as long as possible in their homes with dignity, the services must be integrated.

Self-governments deal with the problem of precise planning, because of the lack of methods in evaluating the true number of people that will need long term care and what particular services they will need. As a result, the self-governments cope with the problem of inadequate planning and finances and incapability to finance timely services’ provision.

Also managerial constraints and financial limitations cause the problems in the provision of long term services, their underdevelopment, the constraints in growth of infrastructure and the decrease in quality of services. To avoid unreasonable increase of the state expenses and negative impact on macroeconomic stability it is essential to define a separate system of funding of all institutions and services of long term care. Also the rules in financing system should be clarified and stabilized.

Finally, the huge informal long term care should be partly substituted by formal home care. New flexible forms of provision of services oriented towards patients’ needs should be introduced and implemented.

⁹ http://www.sam.lt/go.php/eng/Health_Care_Reform/1066, Implementation Strategy of Health Care Reform’s Aims and Objectives

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ANCIEN

Assessing Needs of Care in European Nations



FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).